North Carolina Department of Health and Human Services
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951
Michael Moseley, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
L. Allen Dobson, Jr., MD, Assistant Secretary for Health Policy and Medical Assistance

April 17, 2006

MEMORANDUM

TO: LME Director

FROM: Allen Dobson, MD LADJr

Mike Moseley MM

Subject: EPSDT Reviews

On February 28, 2006, you received instructions regarding the distribution of Medicaid notices to recipients regarding changes in their services as a part of the newly approved mental health/developmental disability/substance abuse services. As a result, you were asked to collect the notices or request forms for services that exceed the limitation or restrictions indicated in the service definitions and to hold them until further instructions were sent out.

We will begin the process of conducting the individual reviews of those cases in a phased-in approach. Our contract agent, Value Options, and DMA staff will begin conducting these reviews in early May. The two phases will be:

- Phase I: As a result of EPSDT, children may continue to need a combination of services or amounts of services that the revised service definitions do not allow. These include services for children who need:
  - more than 8 hours of Community Support services per day; or
  - or more than the 8 units of service allowed per month when provided with other services; or
  - a combination of day treatment and residential services.

  This includes those children who received Notice B or children who received authorization for more than 8 hours of Community Support services per day.
- Phase II: Children with developmental disabilities who
  - have either a mental health or a substance abuse diagnosis and are in need of rehabilitation services rather than habilitation services, and should therefore continue to receive some form of the enhanced benefit package from

community-based support services for children with developmental disabilities; or

- require Community Support services or some other form of Medicaid services - regardless of diagnosis and due to EPSDT, the child may require community support services or some other form of Medicaid services to correct or ameliorate the medical condition.

This includes those children who received Notices E, F and notice G.

We are asking that you submit the attached cover letter documenting the nature of your request, Medicaid identification number and contact information, along with copy of the applicable notice and completed EPSDT Review Request form. This information should be sent by **Friday, April 28, 2006 to:**

Division of Medical Assistance
Assistant Director's Office, Clinical Policy and Programs
RE: MH/DD/SA review
MSC 2501
Raleigh, NC 27699-2501

This information will be forwarded to ValueOptions or the responsible DMA staff for processing and review. We also request that you keep a copy of these documents in your records. ValueOptions or DMA staff may require additional information and will contact the clinician indicated for any follow up documentation or discussion.

All other cases will be reviewed as part of the regular utilization review process that is targeted for implementation beginning June 1. In the interim, the individual's medical record should contain all documentation used to support Medicaid approval and billing. This includes, but is not limited to relevant assessments and evaluations, clinical consultations, current treatment plans, and progress notes.

Thank you for your cooperation, both in holding these requests and in forwarding all of the necessary documentation to us at DMA.

Enclosures
cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH Executive Leadership Team
DMA Senior Management Team
Rob Lamme
Chair, Commission for MH/DD/SAS
Chair, State CFAC
Chair, Coalition 2001

Submit the following information on letterhead of the agency submitting the request

Date submitted_____

EPSDT REVIEW CONCERNING MH/DD/SA SERVICES

Recipient's Name:	MID#:

Services in need of review:	☐ Community Support Services ☐ Day Treatment ☐ Other _____

Provider of service	Name:_____ Clinical Contact: _____ Phone: _____ Fax: _____

Provider of service	Name:_____ Clinical Contact: _____ Phone: _____ Fax: _____

Area Authority Contact:	Name:_____ Clinical Contact: _____ Phone: _____ Fax: _____

Attach applicable notice and documentation

Mail to: Assistant Director's Office, Clinical Policy and Programs
RE: MH/DD/SA review
MSC 2501
Raleigh, NC 27699

EPSDT Review Form for MH/DD/SA Services

Name of Recipient _____ **MID#** _____

Clinician Contact Name _____ **Phone** _____

Answers to the following questions are required to perform an EPSDT review.
All fields must be completed. Indicate N/A where appropriate.

The following questions address the service being requested:
What service(s) is being requested for continuation under EPSDT?
At what intensity and frequency is the service being requested?
What symptoms or behaviors are being targeted by the service?
What are the goals of the requested service?
What is the projected duration of need for service(s)?
What is a projected termination date of the service being requested?
The following questions address current service(s):
Current Medications (List name and dosage, times given):
What is the impact of the service – i.e., what positive changes in symptoms, behaviors, or functioning have occurred which are directly attributable to the service received in the past?
For sex offenders, has a Sex Offender Specific Evaluation (SOSE) been completed? If so, please attach the most current SOSE to this form. Yes _____ No ____
Lower Level of Care is inappropriate or insufficient to meet the needs of the child because: